



**ATHLETE INFORMATION & MEDICAL HISTORY FORM**

Date completed (MM/DD/YY): \_\_\_/\_\_\_/\_\_\_ Last reviewed: 1 yr  2 yrs  3 yrs

**1. Personal Information SOO Registration Number (if known): \_\_\_\_\_**

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_ Apt / Unit # \_\_\_\_\_

City \_\_\_\_\_ Province **ONTARIO** Postal Code \_\_\_\_\_

Home Phone Number ( ) \_\_\_\_\_ Cell Phone Number ( ) \_\_\_\_\_

e-mail (athlete/parent/Guardian) \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date of Birth (MM/DD/YY) Gender: Male  Female

OHIP Number \*This information is provided voluntarily and not required for the completion of this form

**2. Living Arrangements**

Independent  Family  Group Home  Other  \_\_\_\_\_

**3. Emergency Contact(s)**

1. Name \_\_\_\_\_ Relationship to Athlete \_\_\_\_\_

Home Phone Number ( ) \_\_\_\_\_ Cell Phone Number ( ) \_\_\_\_\_

2. Name \_\_\_\_\_ Relationship to Athlete \_\_\_\_\_

Home Phone Number ( ) \_\_\_\_\_ Cell Phone Number ( ) \_\_\_\_\_

**4. Medical Contact(s)**

Family Doctor (please print name) \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_



**5. Medical History**

Please check Yes (Y) or No (N) for all areas

If yes, please specify in the boxes below

Y N

- Food Allergies
- Sting/Bite Allergies
- Medicine Allergies
- Do you carry an epi-pen?
- Asthma
- Do you carry an inhaler?
- Blindness or Visual Problems
- Bone or Joint Problems
- Chest Pain
- Concussion or Serious Head Injury
- Diabetes
- Down Syndrome
- Atlantoaxial Instability
- Easy Bleeding

Y N

- Emotional/Psychological/ Behaviour Problems
- Hearing Loss/Hearing Aid
- Major Surgery or serious illness
- Heat Stroke/Exhaustion
- High Blood Pressure
- Medications (if yes, please indicate below)
- Non-Verbal
- Seizures/Epilepsy/Fainting Spells  
If yes, date of last episode       /      /        
(MM/DD/YY)
- If yes, commonly reoccurring
- Requires Assistance
- Uses Wheelchair
- Other \_\_\_\_\_

If you answered yes to any questions above, please elaborate in the boxes below:

Please explain any medical issues and how to address them (eg. List any allergies, response to seizures, etc., medications required for specific circumstances)

Please indicate any information that will benefit the athlete/coach training relationship (eg. Behaviour management, communications, limitations, etc.)



**6. Medications** (Please attach any additional information necessary)

Does athlete self-medicate? Yes  No

Medication Name	Dosage	Times per Day
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**Important:** I understand that the information contained in this form may be deemed confidential. I affirm that I have read the above and that the information I have given is true and complete. This form must be completed and signed in order to participant in any practice or sporting event

Name (printed) \_\_\_\_\_ Signature \_\_\_\_\_

Relationship to Athlete \_\_\_\_\_ Date \_\_\_\_\_

**Important:** Information must be confirmed by the coaching staff or manager before the first practices of the year.

Date Information	Date Information	Athlete/Guardian Initials	Coach/Manager
Initials			
Confirmed Correct	Revised		

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